



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE FORTH WORTH
PO BOX 1353
FRISCO TEXAS 75034

Respondent Name

CITY OF FORT WORTH

Carrier's Austin Representative

Box Number 04

MFDR Tracking Number

M4-13-2722-01

MFDR Date Received

June 24, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider for this patient is Dr. Michael Lopez. Physical therapy evaluations are completed by our office physical therapist Steve Silvey. This patient had their initial PT evaluation on 10.23.2012 and it was paid in full. Patient has authorization for PT. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. Claims before and after these dates of services have been paid in full. These are incorrect denials, same diagnosis codes as the other claims."

Amount in Dispute: \$344.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the documentation provided these daily services were performed by SL Silvey, PT however the bills were submitted with Michael D Lopez, DC listed in Box 31. As required by the Texas Administrative Code the charges in question should have been submitted for review 'in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care' [Texas Administrative Code Rule 133.20(e)(2)]."

Response Submitted by: Ricky D. Green, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2013 and February 26, 2013	97002, 97112 and 97110	\$344.58	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- Note: Per Rule 133.20 (e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. NAME ON NOTES SL SILVEY, PT.
- 193 – Original payment decision maintained
- B20 – Srvc partially/fully furnished by another provider
- GP – Service delivered under OP PT care plan
- 168 – No additional allowance recommended
- 97 – Charge included in another charge or service
- R79 – CCI: Standards of Medical/Surgical practice

Issues

1. Did the requestor submit medical records for disputed CPT code 97002-GP rendered on February 26, 2013?
2. Did the requestor submit legible medical documentation for disputed CPT codes 97112 and 97110 rendered on February 26, 2013?
3. Did the requestor submit the medical bill in accordance with the provisions of Texas Labor Code §401.011?
4. Did the requestor submit the medical bill in accordance with the provisions of 28 Texas Administrative Code §133.20?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."
 - The requestor submitted medical records dated January 22, 2013, February 25, 2013 and February 26, 2013. The requestor identified the disputed dates of service on the Table of Disputed Services as January 22, 2013 and February 26, 2013.
 - Review of the CMS-1500 and EOBs submitted with the DWC060 request refers to date of service February 26, 2013. The requestor submitted a Physical Therapy Evaluation note for date of service 02/25/2013, however the disputed date of service is 02/26/2013.
2. 28 Texas Administrative Code §133.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division."
 - The requestor submitted two copies of a SOAP note templates dated February 26, 2013 both signed by the injured worker. The first copy contains a signature in the "DR. /PHY. THER. SIGNATURE" line that consists of an illegible initial, with CPT code 97002 circled to identify the service that was rendered on February 26, 2013. The second copy does not contain a signature or initials in the "DR. /PHY. THER. SIGNATURE" and contains two units circled next to CPT codes 97112 and 97110 to identify the services rendered on February 26, 2013.
3. Texas Labor Code §401.011, titled, General Definitions, states in pertinent part. "In this subtitle... (21) "Health care practitioner" means: (A) an individual who is licensed to provide or render and provides or renders health care; or (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.

4. 28 Texas Administrative Code §133.20, titled, Medical Bill Submission by Healthcare Provider, states in pertinent part, (e)(2) states in pertinent part “(e) A medical bill must be submitted: 2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care...”
- The requestor disputes non-payment of CPT code 97002-GP rendered on January 22, 2013 and CPT codes 97112 and 97110 rendered on February 26, 2013.
 - Review of the CMS-1500's for date of service, January 22, 2013 and February 26, 2013 document in box 31 the signature of physician or supplier as Michael Lopez, D.C.
 - Review of the “Physical Therapy Evaluation” note documents that for date of service, January 22, 2013, SL Silvey, PT rendered the physical therapy evaluation.
 - Review of the SOAP notes does not contain a name of the physician or supplier who rendered the services in dispute for date of service, February 26, 2013.
 - The requestor did not meet the billing requirements of 28 Texas Administrative Code §133.20. As a result reimbursement cannot be recommended
5. For the reason stated above, the requestor is not entitled to reimbursement of the disputed charges rendered on January 22, 2013 and February 26, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September 13, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.